



## CHARITABLE DONATION/SPONSOR REQUEST FORM

All requests must be received at least (60) sixty days before the event date or the date the donation is required. Please complete the entire form. If an item does not apply, please enter "NA". Funds are limited and unfortunately all requests cannot be accommodated. All decisions are final.

### ORGANIZATION INFORMATION

Organization Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Contact Person \_\_\_\_\_ Phone Number \_\_\_\_\_

Title \_\_\_\_\_ Email Address \_\_\_\_\_

### DONATION DETAILS

Event Name \_\_\_\_\_ Event Date \_\_\_\_\_

Event Location \_\_\_\_\_ Anticipated Event Attendance \_\_\_\_\_

Requested Donation Cash \$ \_\_\_\_\_ Other \_\_\_\_\_

How will this donation be used? \_\_\_\_\_

Description of Event \_\_\_\_\_

Requests can be mailed to:

Donation Request  
Grace Health  
1019 Cumberland Falls Hwy, Suite B201  
Corbin, KY 40701

Or faxed to:

(606) 528-3871

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For office use only:

Date Received \_\_\_\_\_ Date Sent to Committee \_\_\_\_\_

Committee Determination \_\_\_\_\_